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of the Blue Cross and Blue Shield Association

WESTERN MICHIGAN UNIVERSITY
Group# 007005281/0016/0017/0018/0019/0034/0035/0042
Community Blue PPO℠ ASC
Effective Date: On or after January 2018
Benefits-at-a-glance for AFSCME

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Preauthorization for Select Services - Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by BCBSM except in an emergency.

Note: A list of services that require approval **before** they are provided is available online at **bcbsm.com/importantinfo.** Select ***Approving covered services***.

Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.

Preauthorization for Specialty Pharmaceuticals - BCBSM will pay for FDA-approved specialty pharmaceuticals that meet BCBSM's medical policy criteria for treatment of the condition. The prescribing physician must contact BCBSM to request preauthorization of the drugs. **If preauthorization is not sought, BCBSM will deny the claim and all charges will be the member's responsibility.**

Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other diseases as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

Blue Cross provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Benefits	In-network	Out-of-network
Deductible	$400 for one member, $800 for the family (when two or more members are covered under your contract) each calendar year **Note:** Deductible may be waived for covered services performed in an in-network physician's office and for covered mental health and substance use disorder services that are equivalent to an office visit and performed in an in-network physician's office.	$800 for one member, $1,600 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network deductible amounts also count toward the in-network deductible.
Flat-dollar copays	• $35 copay for office visits and office consultations • $35 copay for medical online visits • $150 copay for emergency room visits • $35 copay for urgent care visits	• $150 copay for emergency room visits
Coinsurance amounts (percent copays) **Note:** Coinsurance amounts apply once the deductible has been met.	• 50% of approved amount for private duty nursing care	• 50% of approved amount for private duty nursing care • 25% of approved amount for substance use disorder treatment • 25% of approved amount for most other covered services
Annual out-of-pocket maximums - applies to deductibles, flat dollar copays and coinsurance amounts for all covered services - including cost-sharing amounts for prescription drugs, if applicable	$1,400 for one member, $2,800 for the family (when two or more members are covered under your contract) each calendar year	$2,800 for one member, $5,600 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum.
Lifetime dollar maximum	None	

Preventive care services

Benefits	In-network	Out-of-network
Health maintenance exam - includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Pap smear screening - laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilization for females	100% (no deductible or copay/coinsurance)	75% after out-of-network deductible
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	100% after out-of-network deductible

Benefits	In-network	Out-of-network
Contraceptive injections	100% (no deductible or copay/coinsurance)	75% after out-of-network deductible
Well-baby and child care visits	100% (no deductible or copay/coinsurance) • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) **Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance.	75% after out-of-network deductible **Note:** Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.
	One per member per calendar year	
Colonoscopy - routine or medically necessary	100% (no deductible or copay/coinsurance) for the first billed colonoscopy **Note:** Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance.	75% after out-of-network deductible
	One per member per calendar year	

Physician office services

Benefits	In-network	Out-of-network
Office visits - must be medically necessary	$35 copay per office visit	75% after out-of-network deductible
Online visits - by physician must be medically necessary **Note:** Online visits by a vendor are not covered.	$35 copay per online visit	75% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	100% after in-network deductible	75% after out-of-network deductible
Office consultations - must be medically necessary	$35 copay per office consultation	75% after out-of-network deductible

Benefits	In-network	Out-of-network
Urgent care visits - must be medically necessary	$35 copay per urgent care visit	75% after out-of-network deductible

Emergency medical care

Benefits	In-network	Out-of-network
Hospital emergency room	$150 copay per visit (copay waived if admitted or for an accidental injury)	$150 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services - must be medically necessary	100% after in-network deductible	100% after in-network deductible

Diagnostic services

Benefits	In-network	Out-of-network
Laboratory and pathology services	100% after in-network deductible	75% after out-of-network deductible
Diagnostic tests and x-rays	100% after in-network deductible	75% after out-of-network deductible
Therapeutic radiology	100% after in-network deductible	75% after out-of-network deductible

Maternity services provided by a physician or certified nurse midwife

Benefits	In-network	Out-of-network
Prenatal care visits	100% (no deductible or copay/coinsurance)	75% after out-of-network deductible
Postnatal care visit	100% (no deductible or copay/coinsurance)	75% after out-of-network deductible
Delivery and nursery care	100% after in-network deductible	75% after out-of-network deductible

Hospital care

Benefits	In-network	Out-of-network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note:** Nonemergency services must be rendered in a **participating** hospital.	100% after in-network deductible Unlimited days	75% after out-of-network deductible
Inpatient consultations	100% after in-network deductible	75% after out-of-network deductible
Chemotherapy	100% after in-network deductible	75% after out-of-network deductible

Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care - must be in a **participating** skilled nursing facility	100% after in-network deductible Limited to a maximum of 120 days per member per calendar year.	100% after in-network deductible

Benefits	In-network	Out-of-network
Hospice care	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods - provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	
Home health care: • must be medically necessary • must be provided by a **participating** home health care agency	100% after in-network deductible	100% after in-network deductible
Infusion therapy: • must be medically necessary • must be given by a **participating** Home Infusion Therapy (HIT) provider or in a **participating** freestanding Ambulatory Infusion Center (AIC) • may use drugs that require preauthorization - consult with your doctor	100% after in-network deductible	100% after in-network deductible

Surgical services

Benefits	In-network	Out-of-network
Surgery - includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	100% after in-network deductible	75% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay/coinsurance)	75% after out-of-network deductible
Voluntary sterilization for males **Note:** For voluntary sterilizations for females, see "**Preventive care services.**"	100% after in-network deductible	75% after out-of-network deductible
Voluntary abortions	100% after in-network deductible	75% after out-of-network deductible

Human organ transplants

Benefits	In-network	Out-of-network
Specified human organ transplants - must be in a **designated** facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) - in designated facilities **only**
Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% after in-network deductible	75% after out-of-network deductible
Specified oncology clinical trials **Note:** BCBSM covers clinical trials in compliance with PPACA.	100% after in-network deductible	75% after out-of-network deductible
Kidney, cornea and skin transplants	100% after in-network deductible	75% after out-of-network deductible

Mental health care and substance use disorder treatment

Note: Some mental health and substance use disorder services are considered by BCBSM to be comparable to an office visit or medical online visit. When a mental health or substance use disorder service is considered by BCBSM to be comparable to an office visit or medical online visit, we will process the claim under your office visit or medical online visit benefit

Note: BCBSM will cover mental health services performed - MD, DO, Fully Licensed Psychologists and Clinical Licensed Master's Social Workers (CLMSWs), Limited Licensed Psychologists (LLPs), Licensed Professional Counselor, Social Workers who have the following social work degrees/certifications: MMSW and MSSW.

Benefits	In-network	Out-of-network
Inpatient mental health care and **inpatient** substance use disorder treatment	100% after in-network deductible	75% after out-of-network deductible
	Unlimited days	
Residential psychiatric treatment facility: • covered mental health services **must** be performed in a residential psychiatric treatment facility • treatment **must** be preauthorized • subject to medical criteria	100% after in-network deductible	75% after out-of-network deductible
Outpatient mental health care: • Facility and clinic	100% after in-network deductible	100% after in-network deductible in participating facilities **only**
• Online visits **Note:** Online visits by a vendor are not covered.	$35 copay per visit	75% after out-of-network deductible
• Physician's office	100% after in-network deductible	75% after out-of-network deductible
Outpatient substance use disorder treatment - in approved facilities **only**	100% after in-network deductible	75% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
Applied behavioral analysis (ABA) treatment - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment.	100% after in-network deductible	100% after in-network deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	100% after in-network deductible	75% after out-of-network deductible
	Physical, speech and occupational therapy **with an autism diagnosis** is unlimited	
Other covered services, including mental health services, for autism spectrum disorder	100% after in-network deductible	75% after out-of-network deductible

Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP) **Note:** Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. **Note:** When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	• 100% after in-network deductible for diabetes medical supplies • 100% (no deductible or copay/coinsurance) for diabetes self-management training	75% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay/coinsurance)	75% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	100% (no deductible or copay/coinsurance)	75% after out-of-network deductible
	Limited to a **combined** 24-visit maximum per member per calendar year	
Outpatient physical, speech and occupational therapy - provided for rehabilitation	100% after in-network deductible	75% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a **combined** 60-visit maximum per member per calendar year	
Durable medical equipment **Note:** DME items required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of covered DME items required under PPACA, call BCBSM.	100% after in-network deductible	100% after in-network deductible
Prosthetic and orthotic appliances	100% after in-network deductible	100% after in-network deductible
Private duty nursing care	50% after in-network deductible	50% after in-network deductible
Massage therapy - payable when performed by a licensed Massage Therapist up to $70 per visit with a prescription from a licensed MD, DO, Chiropractor, Physician Assistant and Nurse Practitioner. **Note:** Limited to 12 visits, per member, per calendar year.	100% after in-network deductible	75% after out-of-network deductible
Temporomandibular joint (TMJ) bite splints	100% (no deductible or copay/coinsurance)	75% after out-of-network deductible
Glucose monitor, diabetic test strips and lancets	100% (no deductible or copay/coinsurance)	75% after out-of-network deductible

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WESTERN MICHIGAN UNIVERSITY
Group# 007005281/0016/0017/0018/0019/0034/0035/0042
BCBSM Preferred RX Program
Effective Date: On or after January 2018
Benefits-at-a-glance for AFSCME

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Specialty Pharmaceutical Drugs - The mail order pharmacy for **specialty drugs** is Walgreens Specialty Pharmacy, LLC, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis, multiple sclerosis and cancer. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many in-network retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Express Scripts. (Express Scripts is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at **bcbsm.com/pharmacy**. If you have any questions, please call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.

We will not pay for more than a 30-day supply of a covered prescription drug that BCBSM defines as a "specialty pharmaceutical" whether or not the drug is obtained from a 90-Day Retail Network provider or mail-order provider. We may make exceptions if a member requires more than a 30-day supply. BCBSM reserves the right to limit the quantity of select specialty drugs to no more than a 15-day supply for each fill. Your copay/coinsurance will be reduced by one-half for each fill once applicable deductibles have been met.

Select Controlled Substance Drugs - BCBSM will limit the initial fill of select controlled substances to a 15-day supply. The member will be responsible for only one-half of their cost-sharing requirement typically imposed on a 30-day fill. Subsequent fills of the same medication will be eligible to be filled as prescribed, subject to the applicable cost-sharing requirement. Select controlled substances affected by this prescription drug requirement are available online at bcbsm.com/pharmacy.

Member's responsibility (copays and coinsurance amounts)

Note: Your prescription drug copays and coinsurance amounts, including mail order copay and coinsurance amounts, are subject to the **same** annual out-of-pocket maximum required under your medical coverage. The following prescription drug expenses will not apply to your annual out-of-pocket maximum.

- any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand name drug
- the 25% member liability for covered drugs obtained from an out-of-network pharmacy

Note: If your prescription is filled by any type of in-network pharmacy, and you request the brand-name drug when a generic equivalent is available on the BCBSM MAC list and the prescriber HSA not indicated "Dispensed as Written" (DAW) on the prescription, you must pay the difference in cost between the brand-name drug dispensed and the maximum allowable cost for the generic **plus** the applicable copay/coinsurance.

Benefits		90-day retail network pharmacy	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Tier 1 - Generic drugs	1 to 30-day period	You pay $15 copay	You pay $15 copay	You pay $15 copay ***plus*** an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	No coverage	No coverage
	84 to 90-day period	You pay $37.50 copay	No coverage	No coverage

Benefits		90-day retail network pharmacy	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Tier 2 - Preferred brand-name drugs	1 to 30-day period	You pay $35 copay	You pay $35 copay	You pay $35 copay ***plus*** an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	No coverage	No coverage
	84 to 90-day period	You pay $87.50 copay	No coverage	No coverage
Tier 3 - Nonpreferred brand-name drugs	1 to 30-day period	You pay $60 copay	You pay $60 copay	You pay $60 copay **plus** an additional 25% of the BCBSM approved amount for the drug
	31 to 83-day period	No coverage	No coverage	No coverage
	84 to 90-day period	You pay $150 copay	No coverage	No coverage
Sindecuse Pharmacy Tier 1 - Generic or select prescribed over-the-counter drugs	1 to 30-day period	You pay $10 copay	You pay $10 copay	Not applicable
	31 to 83-day period	Not applicable	No coverage	Not applicable
	84 to 90-day period	You pay $12.50 copay	No coverage	Not applicable
Sindecuse Pharmacy Tier 2 - Preferred brand-name drugs	1 to 30-day period	You pay $30 copay	You pay $30 copay	Not applicable
	31 to 83-day period	Not applicable	No coverage	Not applicable
	84 to 90-day period	You pay $37.50 copay	No coverage	Not applicable
Sindecuse Pharmacy Tier 3 - Nonpreferred brand-name drugs	1 to 30-day period	You pay $40 copay	You pay $40 copay	Not applicable
	31 to 83-day period	Not applicable	No coverage	Not applicable
	84 to 90-day period	You pay $50 copay	No coverage	Not applicable

Covered services

Benefits	90-day retail network pharmacy	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
FDA-approved drugs	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
State-controlled drugs	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
FDA-approved **generic** and **select brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Other FDA-approved **brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance

Benefits	90-day retail network pharmacy	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% of approved amount	100% of approved amount	75% of approved amount
FDA-approved **generic** and **select brand name** prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount	100% of approved amount	75% of approved amount
Other FDA-approved **brand name** prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs **Note:** Needles and syringes have no copay/ coinsurance.	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	75% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug
Sindecuse Pharmacy **Note:** Covered generic contraceptive medications are $0 copay (brand name contraceptives are subject to member's cost-sharing requirements for Sindecuse Pharmacy) **Note:** Diabetic medications, Diabetic test strips and lancets	Not applicable	Not applicable	

* BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers.

Features of your prescription drug plan

Custom Drug List	A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost. • **Tier 1 (generic)** - Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay/coinsurance, making them the most cost-effective option for the treatment. • **Tier 2 (preferred brand)** - Tier 2 includes brand-name drugs from the Custom Drug List. Preferred brand name drugs are also safe and effective, but require a higher copay/coinsurance. • **Tier 3 (nonpreferred brand)** - Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay/coinsurance for these drugs.
Drug interchange and generic copay/ coinsurance waiver	BCBSM's drug interchange and generic copay/ coinsurance waiver programs encourage physicians to prescribe a less-costly generic equivalent. If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay/ coinsurance. In select cases BCBSM may waive the initial copay/ coinsurance after your prescription HSA been rewritten. BCBSM will notify you if you are eligible for a waiver.
Mandatory maximum allowable cost drugs	If your prescription is filled by any type of network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the **difference** in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug ***plus*** your applicable copay regardless of whether you or your physician requests the brand name drug. **Exception:** If your physician requests and receives authorization for a nonformulary brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, You pay only your applicable copay. **Note:** This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.
Over-the-counter drugs	Excludes benefits for certain over-the-counter drugs.

Features of your prescription drug plan

Dosage and quantity of drugs	Your prescription drug coverage has eliminated authorization requirements for select prescription drugs, and dosages and quantities of drugs.

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WESTERN MICHIGAN UNIVERSITY
Group# 007005281/0016/0017/0018/0019/0034/0035/0042
Dental Coverage
Effective Date: On or after January 2018
Benefits-at-a-glance for AFSCME

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Network access information
With Blue Dental PPO Plus, members can choose any licensed dentist anywhere. However, they'll save the most money when they choose a dentist who is a member of the Blue Dental PPO network.[1]

Blue Dental PPO network- Blue Dental members have unmatched access to PPO dentists through the Blue Dental PPO network, which offers more than 438,000 dentist locations[2] nationwide. PPO dentists agree to accept our approved amount as full payment for covered services - members pay only their applicable coinsurance and deductible amounts. Members also receive discounts on noncovered services when they use PPO dentists (in states where permitted by law). To find a PPO dentist near you, please visit **mibluedentist.com** or call **1-888-826-8152.**
[1]*Blue Dental uses the Dental Network of America (DNoA) Preferred Network for its dental plans.*
[2]*A dentist location is any place a member can see a dentist to receive high-quality dental care. For example, one dentist practicing in two offices would be two dentist locations.*

Blue Par SelectSM arrangement- Most non-PPO dentists accept our Blue Par Select arrangement, which means they participate with the Blues on a "per claim" basis. Members should ask their dentists if they participate with BCBSM before every treatment. Blue Par Select dentists accept our approved amount as full payment for covered services - members pay only applicable coinsurance and deductibles. To find a dentist who may participate with BCBSM, please visit **mibluedentist.com.**

Note: Members who go to nonparticipating dentists are responsible for any difference between our approved amount and the dentist's charge.

Member's responsibility (deductible, coinsurance and dollar maximums)

Benefits	Coverage
Deductible	None
Class I services	10%
Class II services	10%
Class III services	50%
Class IV services	40%
Annual maximum for Class I, II and III services	$2,500 per member
Lifetime maximum for Class IV services	$2,500 per member

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Class I services

Benefits	Coverage
Oral exams	90% of approved amount **Note:** Twice per calendar year
A set (up to 4 films) of bitewing x-rays	90% of approved amount **Note:** Twice per calendar year
Panoramic or full-mouth x-rays	90% of approved amount **Note:** Once every 60 months
Dental prophylaxis (teeth cleaning)	90% of approved amount **Note:** Twice per calendar year
Pit and fissure sealants - for members age 19 and younger	90% of approved amount **Note:** Once per tooth in any 36 consecutive months when applied to the first and second permanent molars
Palliative (emergency) treatment	90% of approved amount
Fluoride treatments	90% of approved amount **Note:** Two per calendar year
Space maintainers - missing posterior (back) primary teeth - for members under age 19	90% of approved amount **Note:** Once per quadrant per lifetime

Class II services

Benefits	Coverage
Fillings - permanent (adult) teeth	90% of approved amount **Note:** Replacement fillings covered after 24 months or more after initial filling
Fillings - primary (child) teeth	90% of approved amount **Note:** Replacement fillings covered after 12 months or more after initial filling
Onlays and inlays restorations - permanent teeth - for members age 12 and older	90% of approved amount **Note:** Once every 60 months per tooth
Recementation of crowns, veneers, inlays, onlays and bridges	90% of approved amount **Note:** Three times per tooth per calendar year after six months from original restoration
Oral surgery, except simple extractions	90% of approved amount
Root canal treatment - permanent tooth	90% of approved amount **Note:** Once every 12 months for tooth with one or more canals
Scaling and root planing	90% of approved amount **Note:** Once every 24 months per quadrant
Full mouth occlusal adjustments	90% of approved amount
Occlusal biteguards	90% of approved amount **Note:** Once every 12 months
General anesthesia or IV sedation	90% of approved amount **Note:** When medically necessary and performed with oral surgery
Repairs and adjustments of a partial or complete denture	90% of approved amount **Note:** Six months or more after denture is delivered
Relining or rebasing of a partial or complete denture	90% of approved amount **Note:** Once per arch in any 36 consecutive months
Tissue conditioning	90% of approved amount **Note:** Once per arch in any 36 consecutive months

Class III services

Benefits	Coverage
Removable dentures (complete and partial)	50% of approved amount **Note:** Once every 60 months
Bridges (fixed partial dentures) - for members age 16 and older	50% of approved amount **Note:** Once every 60 months after original was delivered

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Benefits	Coverage
Endosteal implants - for members age 16 or older who are covered at the time of the actual implant placement	50% of approved amount **Note:** Once per tooth per lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31
Crowns - permanent teeth - for members age 12 and older	50% of approved amount **Note:** Once every 60 months per tooth

Class IV services

Benefits	Coverage
Minor treatment for tooth guidance appliances	60% of approved amount
Minor treatment to control harmful habits	60% of approved amount
Interceptive and comprehensive orthodontic treatment	60% of approved amount
Post-treatment stabilization	60% of approved amount
Cephalometric film (skull) and diagnostic photos	60% of approved amount

Note: For non-urgent, complex or expensive dental treatment such as crowns, bridges or dentures, members should encourage their dentist to submit the claim to Blue Cross for predetermination ***before*** treatment begins.

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WESTERN MICHIGAN UNIVERSITY

Group# 007005281/0016/0017/0018/0019/0034/0035/0042

Vision Coverage

Effective Date: On or after January 2018
Benefits-at-a-glance

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. VSP is an independent company providing vision benefit services for Blues members. To find a VSP doctor, call **1-800-877-7195** or log on to the VSP Web site at **vsp.com.**

Note: Members may choose between prescription glasses (lenses and frame) or contact lenses, but not both

Member's responsibility (copays)

Benefits	VSP network doctor	Non-VSP provider
Eye exam	$10 copay	$10 copay applies to charge
Prescription glasses (lenses and/or frames)	None	None
Medically necessary contact lenses **Note:** No copay is required for prescribed contact lenses that are not medically necessary.	None	None
Annual benefit maximum	BCBSM will pay **up to a benefit maximum of $700** per member, whether obtained from a VSP or Non-VSP provider in any period of 24 consecutive months. You are responsible for any provider charges over the $700 amount.	

Eye exam

Benefits	VSP network doctor	Non-VSP provider
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	$10 copay	Reimbursement up to $50 less $10 copay (member responsiblefor any difference)
	One eye exam in any period of 24 **consecutive** months	

Lenses and frames

Benefits	VSP network doctor	Non-VSP provider
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary.	None	None
	One pair of lenses, with or without frames, in any period of 24 **consecutive** months	
Standard frames	$700 allowance combined for lenses, frames, and contact lenses, or any combination thereof	
Note: All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.	One frame in any period of 24 **consecutive** months	

Contact Lenses

Benefits	VSP network doctor	Non-VSP provider
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	None	None
	Contact lenses up to the allowance in any period of 24 **consecutive** months	
Elective contact lenses that **improve** vision (prescribed, but do not meet criteria of medically necessary)	$700 allowance combined for lenses, frames, and contact lenses, or any combination thereof	
	Contact lenses up to the allowance in any period of 24 **consecutive** months	

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